more PsA drugs before guselkumab and 74% used an anti-TNF drug.

The median drug survival (SD) was 20.6 (2.7) months. 52% of patients experienced the event (discontinuation of treatment) within 30 months of treatment. Persistence was 69.3% (ES:0.07) at 1 year of treatment and it decreased to 43.7% (ES:0.08) at 2 years of treatment.

There were no statistical differences between patients who had been treated with more or less than four previous treatments nor patients with and without comorbidities. However, we found some differences between patients with previous anti-TNF treatments and the ones who didn't use them. 30.8% of patients without Anti-TNF discontinued treatment vs 59.5% who used Anti-TNF before (p=0,075), mean drug survival in the first group (no anti-TNF) (SD) was 26.0(2.0) vs 16.4 (1.8) in the second group (p=0.02). The reason for these results may be because guselkumab is used in initial stages of the disease due to contraindications to anti-TNF.

Conclusion and Relevance As in clinical trials and another real-world study, high persistence rates were observed with guselkumab during the first year. Further real-world research should be conducted to correlate the differences found between patients with previous anti-TNF treatment, as no such differences were found in clinical trials.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

5PSQ-117 TRACEABILITY OF IMPLANTABLE MEDICAL DEVICES/ PATIENT INFORMATION: WHERE DO WE STAND?

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Background and Importance Health traceability of implantable medical devices (IMD) is a major public health issue. In the event of materiovigilance, this information can be used to trace patients who have received an IMD. Legal information relating to IMD is included in the patient file and must be transmitted to the patient on an implant card (Article R5212–42, French Public Health Code).

Aim and Objectives To assess the compliance of this traceability in our facility to comply with the new version of the Contract for the Improvement of Quality and Efficiency of Care (CAQES).

Material and Methods Ten IMD representative of the facility's activity, with different management and financing modes were selected and 50 interventions were analysed. Twenty-seven items were evaluated divided into four areas: traceability by pharmacy (9), by user service (6), traceability of patient information in the electronic patient record (EPR – 9) and transmission to the patients (3). This retrospective analysis was compared to a similar audit conducted in 2020.

Results Compliance rates are 86% for pharmacy traceability, 84% for service traceability, 52% for patient information traceability in the EPR and 96% for information transmission to the patient. There is a loss of information observed between traceability in business software and information recorded as transmitted to the patient, especially for IMD denomination, manufacturer name, lot and serial numbers. Practices vary depending on surgical specialties. The main non-compliances concern the provision of the implant card, the Unique Device Identifier (UDI), and the Individual Healthcare Identifiers (IHI) number, which are not tracked. Since 2020, practices have improved, especially in terms of patient information traceability, which has increased by 43%.

Conclusion and Relevance Despite the positive results for pharmacy and service traceability, the target set by CAQES for 2022–2024 (>75%) is not met for all criteria. Improvement areas include UDI traceability upon receipt and use, integration of the IHI number into the business software, and harmonising processes across different operating rooms. Improvement avenues for patient information traceability involve standardising liaison letters between surgical specialties, interoperability of business software, and traceability of the delivery of the operative report and implant card to the patient, all to maintain a high level of care quality.

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Conflict of Interest No conflict of interest.

5PSQ-118 NON-ACTIVE PRESCRIPTIONS IN AMBULATORY PATIENTS: ANALYSIS AND EFFECT IN CONSULTATION WAITING TIME

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Background and Importance The optimisation of time within the Hospital Outpatient Pharmacy has become an urgent challenge in light of the remarkable surge in activity over recent years. A substantial number of patients arrive without an active prescription, rendering it impossible to dispense their medications promptly, consequently resulting in consultation delays and patient inconvenience.

Aim and Objectives The primary aim of this study is to delineate the chief causes of non-active prescriptions at the point of dispensation and to assess their impact on patient waiting times when attending the Hospital Outpatient Pharmacy.

Material and Methods Between January 2022 and September 2023, we conducted a prospective registration of patients lacking active prescriptions and subsequently selected a random sample for analysis. This investigation encompassed an assessment of the clinical service to which patients were affiliated, the reasons underpinning prescription unavailability, and the temporal discrepancy between the scheduled appointment time and the actual consultation conclusion time. It is essential to emphasise that we considered the appointment time as the moment of consultation entry, assuming zero delays. Data were meticulously gathered from the electronic prescribing software.

Results Our study encompassed a cohort of 81 patients. Among the patients who presented with non-active prescriptions, the implicated Clinical Services comprised Nephrology (21.0%), Rheumatology (21.0%), Neurology (16.0%), Pulmonology (11.1%), Internal Medicine (9.9%), Urology (7.4%), Dermatology (3.7%), Gastroenterology (3.7%), Endocrinology and Nutrition (2.5%), Allergy (1.2%), Haematology (1.2%), and Paediatrics (1.2%).

The rationales behind non-active prescriptions were multifarious: failure to renew prescriptions during the previous

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consultation (63.0%), prescriptions with inadequate validity until the subsequent consultation (21.0%), prescription errors (8.6%), patient non-attendance at the preceding consultation (4.9%), absence of a patient consultation within the last year (1.2%), and rescheduling of the previous consultation (1.2%).

Within our sampled cohort, the median consultation waiting time amounted to 36 minutes, with an extreme delay reaching up to 3 hours.

Conclusion and Relevance As evidenced by this investigation, the absence of an active prescription at the dispensation juncture exerts an adverse influence on the day-to-day operations of the Hospital Outpatient Pharmacy. It is our assertion that enhanced training and more robust communication with the implicated clinical services could prove invaluable in proactively addressing this predicament.

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Conflict of Interest No conflict of interest.

5PSQ-119 REVIEW OF REAL-WORLD MANAGEMENT OF NATALIZUMAB TREATMENT IN MULTIPLE SCLEROSIS: A DOUBLE-EDGED WEAPON

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Background and Importance We know that natalizumab is an effective treatment in patients with relapsing-remitting multiple sclerosis with high activity. More doubts arise regarding its safety which will lead to having to closely monitor the patient.

Aim and Objectives To evaluate the safety of treatment with natalizumab for relapsing-remitting multiple sclerosis (RRMS), specifically John Cunningham virus (JCV) infection that can cause Progressive Multifocal Leukoencephalopathy (PML). Also evaluate effectiveness by counting outbreaks during treatment and time in treatment.

Material and Methods Retrospective observational study since the approval of the drug. All patients with RRMS under treatment with natalizumab were included and the variables sex, age, previous and subsequent treatments, positive JCV serology at any time, duration of treatment, relapses and number of them, and reason for discontinuing treatment were collected. Data was extracted from FarmaTools® software database and the electronic medical.

Results A total of 75 patients were analysed, 47 (63%) of them women. Mean age at the time of initiation of treatment of 41 years (28–69), median number of previous lines of 1 (0–5), being used as first line in 15 patients (20%), second line in 42 patients (56%). The patients analysed were on treatment for an average of 2.6 years, the reasons for suspension being: Positive JCV serology 39 (52%), adverse effects 11 (15%), outbreaks six (8%), progressive worsening five (7%), unknown cause three (4%) and 2 (3%) discontinued due to pregnancy. Nine (12%) are still receiving treatment. Sixteen patients (21%) had an outbreak during the time on treatment.

Conclusion and Relevance A large proportion of the patients analysed manage to reach the 2-year treatment period, after which the risk of JCV infection increases. At that point, the majority of patients discontinue treatment. The drug is well tolerated, with little suspension of treatment due to adverse effects, and is usually chronic fatigue (also associated with the disease). Effective drug, with only 16 patients having an outbreak during treatment. With these data, we can conclude that in our patients it has been an effective treatment, used once the patient has high activity to stop it. Regarding safety, JCV would be the main drawback, requiring close monitoring for possible infection.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

5PSQ-120 PEMBROLIZUMAB IMMUNE-MEDIATED TOXICITY

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Background and Importance Checkpoint inhibitors (ICI) are increasingly used in various cancers. While they offer clinical benefits, they also introduce drug management challenges due to their adverse effects (AE). A notable concern is the potential for severe immune-mediated toxicities, which can pose significant risks to patients. The presented case is unique as it underscores the severe repercussions of immune-mediated toxicity from pembrolizumab.

Aim and Objectives This reports a case of a 70s male with clear cell renal cell carcinoma (ccRCC) who developed severe immune-mediated toxicity following treatment with pembrolizumab. The patient had a history of some comorbidities. The initial presentation was incidental detection of ccRCC post-trauma. His subsequent treatment, adverse reactions, and outcomes form the crux of this case.

Material and Methods The patient was in his 70s, caucasian male, 1.64 m, 58 kg, non-smoker, and non-alcoholic. His medical history included type 2 diabetes, hypertension, nephrolithiasis, benign prostatic hyperplasia, pacemaker implant due to bradycardia. Daily medication: metformin, amlodipine, perindopril/indapamide, acetylsalicylic acid, dutasteride, afluzosin, lactulose, sodium picosulfate. First line treatment with intravenous pembrolizumab 400 mg (6/6 weeks) and axitinib 5 mg twice daily.

Results Days after the first cycle of treatment, the patient presented to the emergency service (ES) with swallowing difficulties, imbalance, and muscle pain. A probable diagnosis of G3 polymyositis with suspected pembrolizumab-induced myopathy was made. Despite suspending the oncology treatment and initiating high-dose corticosteroid therapy, the patient's condition deteriorated. He developed myocarditis leading to severe global dysfunction of left ventricular systolic function. Subsequent treatments including human immunoglobulin and abatacept were unsuccessful, and the patient unfortunately succumbed to cardiorespiratory arrest two weeks later.

Conclusion and Relevance This case report brings attention to the severe immune-mediated toxicity, emphasising the challenges in its management. While acute AE can often be managed with symptom-based approaches and high-dose corticosteroids,[1] this case demonstrates that these measures may sometimes be insufficient. Creating structured protocols and conducting in-depth research is imperative. Medical professionals should remain vigilant to such adverse effects. This case underlines the importance of risk assessment and continuous monitoring of patients on immunotherapies.

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